**Tool for Surveillance Among Facilities Housing Hurricane Katrina Evacuees**

**SUBMIT THIS FORM DAILY BY FAX TO 770-488-7107 OR BY EMAIL TO EOCANALYSIS@CDC.GOV**

If unable to fax or email, or to report unusual disease occurrences, please call 770-488-7100.

Facility name: _____ Phone:_____-_____-_____ Fax:_____-_____-_____

Email:_____ Reported by: _____

**CURRENT FACILITY CENSUS: TOTAL: _____ AGE: ≤2 y _____ >65 y: _____**

**RACE: White _____ Black: _____ Am Ind: _____ Asian: ____ Other: _____ HISPANIC ETHNICITY: _____**

**24 hour reporting period:** Date: ___ /___/____ Time _____am pm **TO** ___/ ___/____ Time_____am pm

**INSTRUCTIONS: You may count a person more than once BUT be as specific as possible**. ***For example, if you suspect measles, classify as such, otherwise classify as rash illness; OR if person has more than one GI symptom, select the most severe.***

| **Syndrome Category** | # patients with condition |
|---|---|
| **Epidemic Disease Potential** | |
| Fever >100.4° F (38° C) ALONE without localizing signs/ symptoms. | ___ ___ ___ |
| Gastrointestinal Illness | ___ ___ ___ |
| Watery Diarrhea (3 or more watery bowel movements per day) AND vomiting | ___ ___ ___ |
| Watery Diarrhea with NO vomiting | ___ ___ ___ |
| Bloody Diarrhea, +/- vomiting | ___ ___ ___ |
| Respiratory illness | ___ ___ ___ |
| Upper respiratory or influenza-like illness (fever + either cough or sore throat) | ___ ___ ___ |
| Tuberculosis, suspected | ___ ___ ___ |
| Pertussis, suspected (whooping cough; chronic cough ≥ 2 weeks) | ___ ___ ___ |
| Lower respiratory tract illness (pneumonia; bronchiolitis/wheezing) | ___ ___ ___ |
| Viral hepatitis, suspected ( jaundice, +/- fever) | ___ ___ ___ |
| Neurologic illness | ___ ___ ___ |
| Meningitis/encephalitis, suspected (fever, stiff neck, headache, mental status change) | ___ ___ ___ |
| Wound infections | ___ ___ ___ |
| Conjunctivitis (red eyes, ocular discharge) | ___ ___ ___ |
| Rash Illness | ___ ___ ___ |
| Suspect chickenpox (vesicular rash) | ___ ___ ___ |
| Suspect measles/rubella (maculopapular rash) | ___ ___ ___ |
| Scabies | ___ ___ ___ |
| Lice | ___ ___ ___ |
| Other Illness (*please specify*): _____ | ___ ___ ___ |
| **Mental Health / Psychological Problems** | |
| Mental Health | ___ ___ ___ |
| Anxiety / Depression / Insomnia | ___ ___ ___ |
| Substance abuse / withdrawal | ___ ___ ___ |
| Disorientation / Confusion | ___ ___ ___ |
| Acute psychosis / Suicidal or Homicidal | ___ ___ ___ |
| Violent behavior | ___ ___ ___ |
| **Injury / Chronic Disease / Other** | |
| Injury | ___ ___ ___ |
| Self-inflicted injury – Intentional (violence) | ___ ___ ___ |
| Assault-related injury – Intentional (violence) | ___ ___ ___ |
| Unintentional injury (accidents) | ___ ___ ___ |
| Heat related injury (not dehydration) | ___ ___ ___ |
| Diabetes Mellitus | ___ ___ ___ |
| Asthma / COPD | ___ ___ ___ |
| High Blood Pressure and other Cardiovascular Diseases | ___ ___ ___ |
| Dehydration | ___ ___ ___ |

**Are you concerned about a possible outbreak? (*Please describe*):** _____

**Total number of patients treated in past 24 hour period: _____ Total number of deaths during past 24 hours: _____**

**Do you need assistance with, or additional resources for any of the following:**

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Physician staffing | □ | □ | Nursing staffing | □ | □ |
| Pharmacist staffing | □ | □ | Mental Health staffing | □ | □ |
| Sanitation/Environmental health | □ | □ | Medications/Drugs/Pharmacy supply | □ | □ |